U.S. Department of Labor Office of Administrative Law Judges
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Issue date: 01Nov2002

In the Matter of :
Kathleen Burke
Widow :
: Case No. 2002-BLA-00215
v. :
Cyprus Shoshone Coal Co., :
Employer :
:
and :
Director, Office of Workers' :
Compensation Programs :
Party-in-Interest :

DECISION AND ORDER
Denying Benefits
Jurisdiction and Claim History

This case comes on a request for hearing filed by **Kathleen Burke,** Claimant, surviving spouse of **William Burke**, pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§901 *et seq.* (the Act). The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.
4. However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" or "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

Mr. Burke filed a living miner's claim for Federal Black Lung benefits on September 28, 1992. DX 36-1[1]. It was denied by the Department of Labor on March 9, 1993. DX 36-14. He appealed the denial to the Office of Administrative Law Judges and was denied again by a Decision and Order dated January 11, 1995. DX 36-43. Several months later he requested modification (DX36-44), but denied by a Department of Labor District Director's decision dated August 1, 1995. DX 36-48. He appealed that decision, but it was denied by an Office of Administrative Law Judges Decision and Order dated May 6, 1997. DX 36-62. Mr. Burke died on November 28, 1997 (DX 1, DX 4, DX 4). Mrs. Burke filed a widow's claim on July 1, 2000. DX 1. Her claim was denied by the Department of Labor on December 11, 2001. DX 33.

A formal hearing was held in Middlesboro, Kentucky on August 20, 2002, at which time all parties were afforded a full opportunity to present evidence and argument, as provided in the

[1] "DX" connotes "Director's Exhibit".

Act and the regulations found in Title 20 Code of Federal Regulations. The Claimant was represented at hearing by Monica Rice Smith, Esquire, Hyden, Kentucky. Scott White, Esquire, White and Risse, St. Louis, Missouri, represented the Operator. Mrs. Burke was the sole witness. Thirty seven (37) Director's Exhibits (hereafter marked as "DX" 1-37) were admitted into evidence. The Claimant did not submit any exhibits. Four(4) Employer exhibits (marked as EX 1-4) were admitted without objection. After testimony was taken, the parties agreed that briefs would be submitted thirty days after receipt of the transcript[2] of this proceeding. Subsequently, the Operator filed a brief by Vincent G. Rapp, Esquire of White & Risse, and Mr. White's associate. The Claimant did not file a brief.

Issue

The sole issue I will decide is whether the decedent miner died due to pneumoconiosis. During the hearing the Employer did not stipulate that Mr. Burke had pneumoconiosis, but in the Employer's brief, the Employer acquiesced on this issue.

Stipulations

The parties stipulated to the following:

1. The life claims brought by the deceased Miner are not at issue in this case (Tr 7-8).
2. Mr. Burke spent twenty one (21) years in coal mine employment (Tr 8).
3. The Claimant is a survivor of the deceased Miner (Tr 8).
4. The Employer is the Responsible Operator under the Act (Tr 8).
5. There is no issue regarding post 1969 employment (Tr 8).

Regulations

Normally, in a Part 718 survivor's claim, a judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. §§ 718.202(a) prior to considering whether Mr. Burke's death was due to the disease under §§ 718.205. Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

> (1) competent medical evidence established that the Miner's death was due to pneumoconiosis; or
>
> (2) pneumoconiosis was a substantially contributing cause or factor leading to the Miner's death or the death was caused by complications of pneumoconiosis; or
>
> (3) the presumption of §§ 718.304 [complicated pneumoconiosis] is applicable.

20 C.F.R. §§ 718.205(c). Any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. ***Northern Coal Co. v. Director, OWCP***, 100 F.3d 871 (10th Cir. 1996) (a survivor is entitled to benefits if pneumoconiosis hastened the miner's death "to any degree"). See also ***Brown v. Rock Creek Mining Corp***., 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting);.***Island Creek Coal Co. v. Cooley***, 182 F.3d 917(6th Cir., 1999);***Wolf Creek Collieries v. Director, Office of Workers' Compensation Programs***, 298 F.3d 511(6th Cir.,2002).

Similar to ***Northern Coal***, the Sixth Circuit reaffirmed its holding in ***Brown*** to state that benefits are awarded to a survivor who establishes that "'pneumoconiosis is a substantially contributing cause or factor leading to the miner's death if it serves to hasten that death in any way.'" ***Griffith v. Director, OWCP***, 49 F.3d 184 (6th Cir. 1995). But see ***Johnson v. Peabody Coal Co.***, 26 F.3d 618 (6th Cir. 1994) (survivor not awarded benefits where theory of entitlement was that "her husband was severely depressed at the time he committed suicide and that his depression was caused by his illnesses, including pneumoconiosis").

"Substantial contributing factor" and "hastens death" are relative measures that may be viewed as part of the Claimant's burden of proof. The assignment of the burden of proof is a rule

[2] Hereinafter indentified as "Tr".

of substantive law.[3] "Burden of proof," as used in the this setting and under the Administrative Procedure Act[4] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof". "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d)[5]. The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [Ondecko], 512 U.S. 267, 114 S.Ct. 2251 (1994).[6]

A claimant has the general burden of establishing entitlement *and* the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.[7] Therefore, the claimant cannot rely on the Director to gather evidence.[8] Failure to prove any of the requisite elements under the Act (in either a living miner's claim or a survivor's claim) compels a denial of benefits. ***Anderson v. Valley Camp of Utah, Inc.,*** 12 BLR 1-111 (1989); ***Baumgartner v. Director, OWCP***, 9 BLR 1-65 (1986); A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1-860 (1985).

Statement of the Facts

Mr. Burke was born January 22, 1939 and died on November 28, 1997. DX1. He married Kathleen Burke on July 3, 1965. DX36-44. Mrs. Burke was born on September 15, 1948. DX1. Mr. Burke testified at a hearing on December 18, 1996 that he had 21 years of coal mine employment. DX36-60 at 9. His last full year of coal mine employment was in Wyoming for Cyprus Shoshone. Id. The Employer stipulates to 21 years of qualifying coal mine work. Tr. at 8. His last job was in Wyoming where he sustained a back injury and could not work any longer. Tr. at 19. Prior to his one year of employment in Wyoming, Mr. Burke's coal mine employment was in Kentucky. Mr. Burke testified that he had a smoking history of forty (40) years at one-half (½) pack per day. DX36-60 at 16.

Mr. Burke passed away November 28, 1997 at home (Tr 10, DX 1, DX 3, DX 4). Mrs. Burke has not remarried (Tr 10). The couple were married thirty three (33) years, and had five (5) children, all grown and none of them are dependents (Id.).

When he was working, Mr. Burke was principally a "dozer" operator. A bulldozer is heavy machinery that is a tractor with a pneumatically operated blade on it. He would go to work immaculately clean but by the end of a work day would be covered in coal dust (Tr 11-13). In two of the twenty one years, he was a coal truck driver (Id.). Treatment records an prior testimony

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[3] ***American Dredging Co. v. Miller***, 510 U.S. 443, 454, 114 S.Ct. 981, 988, 127 L.Ed.2d 285 (1994)).

[4]33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

[5] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [*Sainz*], 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier..

[6] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev.1981).

[7] ***Id***, *also see* ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

[8] ***Id***.

shows that his duties included rock dusting, working on a belt line, shoveling, setting crib blocks, working "shots", timbering, and hauling dirt as a truck driver (DX 36).

The Claimant testified that her husband had coughing spells "till he would lose his breath." Tr 11). He also was limited in his capacity to walk, and at night had times when he would "stop" breathing (Tr 13). According to the Claimant, in 1975 a physician in Lexington, Kentucky advised Mr. Burke to quit working in an environment the exposed him to coal dust (Tr 12). She asserts that Mr. Burke was examined by a physician, x-rays were taken and she was sent a letter to that effect, but the letter has been lost or misplaced. (Id.). From that time, the breathing problems worsened with time (Tr 18-19). He last worked in 1992 in Wyoming, where he had worked about a year, and injured his back (Tr 14, 19). Subsequently, he had back surgery (Tr 15). Later, he had cancer (Id.). Medications to aid in breathing were prescribed by Mr. Burke's oncologist (Tr 16). He was told that the cancer had metastasized (Tr 17). Before death, on Thanksgiving, 1997, he had difficulty breathing, gasping for air (Tr 18). He passed away the following day.

On cross examination, the Claimant admitted that her husband had smoked cigarettes, on average a pack and a half per day, but that he had reduced his intake to three or four cigarettes per day after he had been diagnosed with cancer (Tr 20-21).

The record shows that by early 1997 Mr. Burke was having difficulty breathing, and was coughing up blood regularly. A chest X-Ray of March 3, 1997, was read by Dr. S. Srisumrid as being negative except for slight prominence of left hilum as compared to the right hilum. A CT scan of the chest, done the same day, was read by Dr. Srisumrid as showing hilar nodes calcifications but no lung tumor or mediastinal mass, a normal chest wall, a small discoid atelectatic area and the retained bullet adjacent to the right pericardium were reported. DX 6.

On April 9, 1997 Mr. Burke, then 58 years old, underwent a bronchoscopy at the Fort Sanders Regional Medical Center in Knoxville, Tennessee, because of his hemoptysis and presence of the nodule in the upper lobe of the left lung..The report of the surgeon, Dr. Christian Stauber, stated that "the Miner denies any significant dyspnea. He denied any significant yellow or green sputum but complained of hemoptysis still. The hemoptysis occurred throughout the day and was fairly constant. The amount he coughed up was about 1-2 teaspoons over a 24-hours period. He denies any chest pain. He denies any weight loss. No fever or chills." DX 6, DX 22.

The physical examination prior to bronchoscopy revealed Mr. Burke to be afebrile with vital signs stable. The lungs were clear and the heart rate regular with no murmurs. A Ct scan revealed a 1.5 cm. density in the right upper lobe. The hemogram and bleeding and clotting parameters were normal.

The bronchoscopy procedure went uneventfully. DX 6, DX 9, DX 36.

The bronchoscopy revealed diffuse bronchitic changes, with a small endo-bronchial lesion surrounded by hemorrhage, present in the apico-posterior segment of the left upper lobe.

An endo-bronchial biopsy, brushing and Iavage were taken from the affected area. The endo-bronchial biopsy was diagnosed by Dr. Michael L. Dyer, a pathologist with Fort Sanders Regional Medical Center, as showing: a poorly differentiated non small cell carcinoma. Bronchial brushing showed a cellular pattern consistent with squamous cell carcinoma. DX 22.

A bone scan done on April 25, 1997, revealed abnormal activity in the left sternoclavicular region and in the right second rib. DX 6.

On May 6, 1997, Mr. Burke was examined by Dr. Spence McCachren, with the Thompson Oncology Group in Knoxville. Dr. McCachren's notes recapitulated Mr. Burke's recent respiratory symptomatology, indicating that the Miner then 58 year-old, started to have in January 1997, symptoms of chest congestion and no fever or sinus involvement, that did not respond to antibiotics. Subsequently Mr. Burke experienced intermittent hemoptysis for 3-4 months. Chest X-Rays and a CT scan of the chest showed a 1.5 cm. density in the right upper lobe and the CT scan showed evidence of bilateral hilar adenopathy and a left paraaortic mass. A small mass was also seen in the right upper lobe, possibly a scar but which could have been malignant. A fluid lesion was seen in the liver.

Mr. Burke complained of pain in the upper sternum. The Miner had lost 19 pounds since the

beginning of 1997. DX 6.

The physical examination on May 6, 1997, revealed a "well appearing man in no acute distress." The vital signs were reported "normal." No lymph nodes were palpated. The lungs were generally clear except for a few crackles. The cardiac findings were unremarkable. Slight tenderness was present on the right side of the sternum. A further review of the CT scan of the chest revealed an apparent expansile and destructive lesions involving the sternum.. The diagnostic assessment was: Stage IV Squamous cell carcinoma of lung with metastatic disease involving the sternum. Dr. McCachren discussed with Mr. Burke and his family the treatment options, and they chose initial chemotherapy and possible later radiation. Mr. Burke was seen again by Dr. McCachren on June 20, 1997. Mr. Burke had at that time completed two cycles of chemotherapy with Carboplatin and Taxol. Dr. McCachren noted indicates that Mr. Burke's pain had totally resolved, his activity was back to normal and he had no complaints. On examination the Miner was "well appearing", was afebrile and was in no distress. The vital signs were normal. There were no lymph nodes palpable. The deformity in his sternum and the tenderness had totally resolved. Mr. Burke's lungs were clear. The heart findings were normal and the remainder of the examination, unremarkable. Id.

A chest X-Ray done on June 20, 1997, was read by Dr. Gayle E. Roulier, a radiologist with Fort Sanders Health System, as showing coarse interstitial lung markings, and hyper-expanded lungs suggestive COPD. Minimal blunting of the costo-phrenic angles reflected possible pleural thickening or scarring. A bullet fragment was seen in the right hilum. Bilateral hilar fullness was still present but had declined in size, The diagnostic assessment was : excellent symptomatic response to two cycles of
chemotherapy, and Mr. Burke had another cycle on examination day, out of the planned total of 6 cycles. DX 22.

On July 15,1997, the Miner was seen again by Dr. McCachen for his fourth cycle of chemotherapy. Mr. Burke reported that he continued to feel well. Mr. Burke was on Albuterol inhaler, Phenargan for nausea, Ativan for anxiety, and still took Tylenol #3 for sternal tightness.Physical finding revealed clear lungs, a large lipoma on the left back and a swelling of the upper part of the sternum, The remainder of the examination was unremarkable. Laboratory tests showed a hemoglobin of 12.9 gm/dI, a hematocrit of 28, and 231,000 platelets. The diagnostic assessment was: Stage IV squamous cell carcinoma with good response to chemotherapy. DX 22.

Mr. Burke was seen again by Dr. Mc.Cachren on September 2, 1997, for his fourth cycle of chemotherapy. Mr. Burke had tolerated the treatment without difficulty. Mr. Burke continued to feel well and was asymptomatic. Mr. Burke denied exertional chest pain, palpitations or syncope. He reported a 24 hours long transient episode of aching in hips and knees, that occurred three days after the chemotherapy. The physical examination was unremarkable, except for a slight, non-tender bulge over the upper sternum and that over the lungs scattered crackles were heard, that cleared with cough.
The diagnostic assessment was: Non small cell carcinoma of lung, arising in the upper lobe with left hilar adenopathy, probable right pen-tracheal node and with erosion into the sternum. No metastases were found elsewhere. Id.

For the sixth cycle of chemotherapy, Mr. Burke was seen by Dr. Richard Grapski, on October 10.1997. DX 9. Mr. Burke continued to report that he was feeling well except for some chronic low back pain. He continued to smoke. Mr. Burke had no bony tenderness, his lungs were clear and the remainder of the physical examination was unremarkable. The Miner was scheduled for further evaluation in three weeks to determine if additional chemotherapy or radiation Needed to have been administered. Id.

On November 10, 1997, Mr. Burke was seen in follow up by Dr. Grapski. The tumor masses continued to improve significantly. A CT scan revealed that the nodule in the right lung had shrunk from 15 to 5 mm and no conglomerates of nodes were seen along the aortic arch. It was decided to give the Miner a final cycle of chemotherapy and then to consider radiation

therapy. Id.

When seen again by Dr. Grapski on November 17, 1997, Mr. Burke's condition was unchanged, Mr. Burke was scheduled for a further five weeks of radiation therapy and the possible side effects of the treatment was explained to him. Id.

In the afternoon of November 28, 1997, at 4:44 p.m., Mr. Burke arrived at the emergency room ("ER") of Appalachian Regional Health Care Harlan-ARH Hospital, with CPR in progress. The CPR was started by the wife at home approximately twenty minutes before arrival to the ER. The endotracheal tube was in place. The monitor showed asystole and no spontaneous respiration. The skin was cool and cyanotic. Resuscitation efforts were unsuccessful and at 6:92 the code was called off and Mr. Burke was pronounced dead. A chest autopsy was performed on December 1,1997, by Dr. N.R. Bathija, at Harlan -ARH Hospital in Harlan Kentucky.

Summary of Medical Evidence

Chest X-ray Evidence

Exhibit	X-ray Date	Date Read	Physician/Qualifications	Reading
DX36-51	03/06/91	11/27/95	Spitz/PR, BCR, B	Unreadable
DX36-13				
DX36-25				
DX36-31	10/22/92	10/22/92	Dahhan/B	Negative
DX36-34	10/22/92	10/04/93	Halbert/BCR B	Negative
DX36-12	10/22/92	11/10/92	Sargent/BCR, B	Negative
DX36-26	10/22/92	05/13/93	Spitz/PR, BCR, B	Negative
DX36-27	10/22/92	06/01/93	Spitz/PR, BCR, B	Negative
DX36-27	10/22/92	05/22/93	Wiot/PR, BCR, B	Negative
DX36-28	07/01/93	07/01/93	Broudy/B	0/1, p/s, mid and lower lung zones
DX36-34	07/01/93	09/16/93	Halbert/BCR B	Negative
DX36-33	07/01/93	09/03/93	Manning/B	0/1, p/s, mid and lower lung zones
DX36-41	07/01/93	06/02/94	Marshall/BCR, B	2/1, p/q, all 6 lung zones
DX36-42	07/01/93	06/14/94	Mathur/BCR, B	1/1, p/s, all 6 lung zones
DX36-50	07/01/93	11/27/95	Poulos/BCR, B	Negative
DX36-52	07/01/93	12/04/95	West/?	Negative
DX36-31	07/01/93	08/26/93	Wiot/PR, BCR, B	Negative
DX36-51	08/15/94	11/27/95	Spitz/PR, BCR, B	Completely negative
DX36-59	08/19/96	08/20/96	Fino/B	Completely negative

Pulmonary Function Study Evidence

Exhibit	PFT Date Coop/Comp	Physician	Age/Ht (in)	FEV1	FVC	MVV
DX36-9	10/22/92	Dahhan	53/69"	2.51/	3.98/	93.14/ good
DX36-25				2.34	3.76	80.75
DX36-31						
DX36-28	07/01/93	Broudy	54/69"	2.74	4.46	92
DX36-59	08/20/96	Fino	57/69	2.55/ 2.66	4.24/ 4.22	not done good

Arterial Blood Gas Study Evidence

Exhibit	ABG Date	Physician	pO2	pCO2
DX36-11; DX36-25; DX36-31	10/22/92	Dahhan	67.9/97.4	34.4/32.9
DX36-28	07/01/93	Broudy	65.7	37.3

Medical Exam Reports

Dr. Dahhan examined Mr. Burke on October 22, 1992 at the request of the Department of Labor . DX36-10, DX36-9. Dr. Dahhan obtained a medical and smoking history from Mr. Burke. He took note of recent cervical spine injury, and disc surgery, as well as Mr. Burke's history of smoking one-half pack per day since 1944. Dr. Dahhan obtained a chest x-ray, pulmonary function test with and without bronchodilators, an arterial blood gas study at rest and during exercise, and an EKG. Dr. Dahhan concluded that Mr. Burke had COPD due to smoking, but he retained the capacity, from a respiratory standpoint, to return to his previous coal mining job.

Dr. Broudy examined Mr. Burke for the Operator on July 1, 1993. DX36-28. Dr. Broudy obtained a medical, social, and occupational history from Mr. Burke. Dr. Broudy took note of 21 years of coal mine employment, and neck and back injuries that ended his coal mining career. Mr. Burke reported a smoking history of 30 years at one-half pack per day. Dr. Broudy obtained a chest x-ray, a pulmonary function test without bronchodilators, and an arterial blood gas study at rest. Dr. Broudy observed changes on the chest x-ray similar to coal workers' pneumoconiosis, but the profusion of the opacities was not sufficient to qualify as coal workers' pneumoconiosis. His final diagnosis was chronic bronchitis with mild COPD due to cigarette smoking. Dr. Broudy opined that Mr. Burke retained the respiratory functional capacity to perform the work of an underground miner. DX36-28.

Dr. Fino examined Mr. Burke for the Operator on August 20, 1996. DX36-59. Mr. Burke reported that he continued to smoke one-half to one pack per day, having started in 1952 (age 13). Mr. Burke reported 21 years of coal mine employment ending in 1992 due to injuries to his back and neck. Dr. Fino obtained a chest x-ray, pulmonary function test with and without bronchodilators, a resting ABG study, and a serum carboxyhemoglobin. Based on those test results, he diagnosed a "mild obstruction consistent with smoking". Dr. Fino explains that Mr. Burke has an obstructive abnormality without evidence of interstitial disease. He concludes, "There is insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis."

Pathology Evidence

Exhibit	Date	Physician	Type
DX3	11/28/97	Creech, Clyde (Bell Co. Coroner)	Certificate of Death
DX4	11/29/97	Bathija, Dr. N.R.	Autopsy report
DX23	12/07/00	Bathija, Dr. N.R.	Opinion letter
DX24	04/25/01	Perper, Dr. Joshua A.	Review report
DX25	07/07/01	Naeye, Dr. Richard L.	Review report
DX30	08/17/01	Caffrey, Dr. P. Raphael	Review report
DX32	10/08/01	Oesterling, Dr. Everett F.	Review report

The death certificate was signed by Mr. Clyde Creech, the Bell County Coroner. DX3. Mr. Creech is not a physician and his qualifications, if any, are not in the record. Mr. Creech listed the cause of death as lung cancer, but there is no explanation as to the basis for that determination. DX3.

Dr. Bathija, the staff pathologist at Appalachian Regional Healthcare Hospital of Harlan, Kentucky, conducted an autopsy on Mr. Burke, and prepared an autopsy report dated January 7, 1998. DX4. Dr. Bathija observed many serious cardiac abnormalities including evidence of prior heart attack and an enlarged heart. In the lungs, Dr. Bathija observed that Mr. Burke had emphysema, a bullet in the right upper lobe, lung cancer, enlarged lymph nodes, and simple coal workers' pneumoconiosis.

Dr. Bathija prepared a one page response to the Department of Labor's request for an explanation regarding the cause of death for Mr. Burke. DX23. He states that he never saw Mr. Burke, and not much clinical information was available, and therefore it is difficult for him to provide a definite opinion, but pneumoconiosis may have contributed to Mr. Burke's death. He suggests clinical correlation.

Dr. Perper reviewed the autopsy slides, and the other medical evidence, and prepared a consultation report dated April 25, 2001. DX24. Dr. Perper is currently a Professor of Pathology and Epidemiology at the University of Miami School of Medicine. DX24A. Dr. Perper lists each piece of evidence that he reviewed, and then outlined the facts contained therein, in chronological order, under such broad headings such as "clinical history". Dr. Perper then described 21 autopsy glass slides in detail. in response to the question regarding the presence of coal workers' pneumoconiosis in Mr. Burke, Dr. Perper states that he had a mild form of coal workers' pneumoconiosis, primarily limited to the pleural and immediate subpleural area. As to whether Mr. Burke's mild coal workers' pneumoconiosis contributed to or hastened his death, Dr. Perper says no, and provides a comprehensive and thorough explanation to support his answer. Mr. Burke's coal workers' pneumoconiosis was so mild that it was insufficient to cause pulmonary disability or to contribute substantially to his death or to hasten his death. DX24.

Dr. Naeye reviewed the medical evidence, and the autopsy slides, and prepared a consultation report dated July 7, 2001. DX25. Dr. Naeye is a Professor of Pathology at Pennsylvania State University College of Medicine. Based on the medical evidence he was provided, Dr. Naeye explains Mr. Burke's medical, social, and occupational history leading up to his death on November 28, 1997 at age 58. The pulmonary function test conducted in September of 1996, 14 months prior to his death, indicated that Mr. Burke had small airways obstruction, but it was too mild to prevent him from "performing all of the requirements of his last job".

Dr. Naeye provides a detailed description and analysis of the lung tissue and the pathology slides. Although he observes micronodules of mild, simple coal workers' pneumoconiosis, their small size, small numbers, and location in the subpleural sites indicate that this disease process could not have caused a problem with lung function that could be measured by pulmonary function tests or arterial blood gas studies. Because the disease was so mild, it could not have caused Mr. Burke any disability or contributed to, or hastened his death. DX25.

Dr. Caffrey reviewed the autopsy slides of Mr. Burke, as well as all of the medical evidence in the record, and prepared an undated consultation report that was submitted to the DOL as evidence accompanied by a letter dated August 25, 2001. DX30. Dr. Caffrey's CV is attached to his report. He is Board Certified in Anatomical, and Clinical Pathology.

Dr. Caffrey lists each piece of medical evidence that he reviewed, and then describes his findings on the autopsy slides. Fifteen of the slides have lung tissue. Based on the autopsy slides, Dr. Caffrey finds the following:

A. Simple coal workers' pneumoconiosis, mild.
B. Centriacinar emphysema, moderate.
C. Focal subpleural fibrosis.
D. Acute passive congestion of lungs.
E. Chronic bronchitis, mild.
F. Micro and macro nodules identified within hilar lymph nodes with probable metastatic carcinoma to one large lymph node from the left lung.

After discussing Mr. Burke's smoking history, and medical history, Dr. Caffrey explains his opinion regarding Mr. Burke's lungs at the time of his autopsy. Dr. Caffrey opines that Mr. Burke had micronodules that appeared to be simple coal workers' pneumoconiosis or simple silicosis - he could not be exactly sure - however, "It is definitely a mild case because of the paucity of the lesions. A number of the slides from both the right and left lungs, for example, did not show any lesions of coal workers' pneumoconiosis, or of simple silicosis." Dr. Caffrey concludes with his opinion that Mr. Burke's simple coal workers' pneumoconiosis was of a mild degree, and did not cause him pulmonary disability and did not cause, contribute to, or hasten his

death.

Dr. Everett F. Oesterling, Jr. reviewed the medical evidence of record and 20 autopsy slides, and prepared a consultation report dated October 8, 2001. DX32. Dr. Oesterling is the Chairman of the Department of Pathology at Ohio Valley General Hospital in Pittsburgh, Pennsylvania. Dr. Oesterling takes note of receiving 20 slides and describes each of the lung tissue slides in detail. Dr. Oesterling took 34 photos of the lung slides, and used the photos to explain his findings and conclusions. Dr. Oesterling finds that Mr. Burke met the minimum requirements for a diagnosis of micronodular coal workers' pneumoconiosis, but he classifies it as "minimal" and finds that it is limited to the pleura and the immediate subpleural tissues. The parenchyma of the lung (where gas exchange occurs) did not show coal workers' pneumoconiosis, only "mild anthracotic pigmentation". Based on these findings, he explains that it was too mild to be a factor in any pulmonary disability that Mr. Burke had, and could not have been a contributing factor or a causative factor in Mr. Burke's death.

Medical Records

Exhibit	Providing Doctor/Facility
DX36-56	Day, Dr. George (Family Medical Clinic)
DX22	Fort Sanders Medical Center
DX9	Grapski, Dr. Richard T.
DX7	Kaw, Dr. Vincent
DX8	Limler, Dr. Jerry
DX6	McCrachren, Dr. S. Spence

In the living miner's claim filed by Mr. Burke, there are nine pages of medical records from Dr. Day. DX36-56. These records are handwritten notes by Dr. Day for several outpatient visits to him by Mr. Burke for complaints of epigastric pain, back pain, and suture removal following disc fusion surgery. These documents cover five or six visits from 1985 through 1992. These documents are contained within the documents provided by Dr. Limler (DX8).

The Department of Labor obtained seven pages of medical records from Ft. Sanders Medical Center. DX22. These records concern the April 9, 1997 hospitalization for bronchoscopy, and biopsy of a right upper lung tumor. The pathology reports indicates it was positive for malignant cells. These records also contain a bone scan report dated April 25, 1997, which indicates Mr. Burke had abnormal activity in the chest.

The Department of Labor obtained 23 pages of medical records from Dr. Grapski of Cumberland Gap, Tennessee. These records document chemotherapy treatment and related radiographical tests administered to Mr. Burke over the course of time from May 6, 1997 through November 17, 1997. He received seven cycles of carboplatin/taxol with significant improvement of the tumor.

The Department of Labor obtained one page of medical records from Kaw. DX7. This consists of a chest x-ray report regarding the March 3, 1997 chest x-ray and CT scan. This report indicates the presence of a bullet in the chest of Mr. Burke, but says nothing about a tumor.

The Department of Labor obtained 31 pages of medical records from Dr. Limler of Cumberland Gap, Tennessee. These records span testing and medical care from March 4, 1994 through November 10, 1997. Many pages were devoted to laboratory testing and radiographical testing, but there were seven physician visits for epigastric pain, suture removal after spinal fusion, complaints of bad back, and for evaluation of hemoptysis. In March of 1997 when symptoms of hemoptysis persisted, the doctor ordered a CT scan which indicated Mr. Burke had a lung mass. He was referred for further evaluation to a pulmonologist.

The Department of Labor obtained 24 pages of medical records from Dr. McCrachren. DX6. Dr. McCrachren's medical records reflect the initial evaluation of Mr. Burke for chemotherapy, which was done on May 6, 1997 and three subsequent progress notes in June, July, and September of 1997. After September 2, 1997, Mr. Burke's chemotherapy was administered by Dr. Grapski and his records are included with this set, but are duplicative of the records the DOL received from Dr. Grapski. These records indicate that Mr. Burke had a very

positive response to the chemotherapy in that the tumor size decreased and his pain symptoms were eliminated. DX6.

Employer Medical Reports

Dr. Tuteur reviewed the medical evidence in the record on behalf of the Operator and prepared a report dated July 20, 2001. DX28. Dr. Tuteur took note that Mr. Burke died suddenly on November 28, 1997 at the age of 58. He observed that Mr. Burke had 21 years of coal mine employment, which ended on February 22, 1992 due to a spinal cord injury. He notes a history of cigarette smoking one-half per day or more beginning in 1958. Mr. Burke was diagnosed with lung cancer on April 9, 1997 by biopsy. Dr. Tuteur takes note of past medical history, which includes a gun shot wound to the chest and some period of "heavy" alcohol intake. The radiographic reports indicate that there was no detectable coal workers' pneumoconiosis, but on autopsy very mild simple coal workers' pneumoconiosis was observed. On November 28, 1997, Mr. Burke died suddenly from advanced coronary artery disease. The autopsy revealed no parenchymal abnormalities associated with cancer, coal workers' pneumoconiosis or any other cause. Dr. Tuteur notes that although there was evidence of very mild coal workers' pneumoconiosis by autopsy it was of insufficient severity, and profusion to produce clinical symptoms, physical examination abnormalities, physiologic impairment, or even radiographic abnormalities. Dr. Tuteur reviews the objective data gathered on Mr. Burke over the years and explains that coal workers' pneumoconiosis did not cause or even hasten Mr. Burke's death because it was too mild. Instead, Mr. Burke's death was caused by coronary artery disease and was affected by his other health problems such as lung cancer, and the radiation and the chemotherapy he was receiving to treat it. DX28.

Dr. Dahhan reviewed the medical evidence in the file on behalf of the Operator and prepared a report dated August 13, 2001. DX 29. He prepared a short summary of each item he reviewed including his own exam report dated October 22, 1992 and then listed his conclusions one through six. Dr. Dahhan explains that although there were pathological findings of very mild coal workers' pneumoconiosis, there was no evidence to justify a diagnosis of progressive massive fibrosis or complicated coal workers' pneumoconiosis. Mr. Burke had a very mild pulmonary impairment that was not disabling based on the various clinical and physiological assessments of his respiratory systems. Mr. Burke's death was not caused or aggravated by the inhalation of coal dust, and Mr. Burke would have died in the same manner regardless of whether or not he ever worked in the coal mining industry. DX 29.

Dr. Renn reviewed the medical evidence of record on behalf of the Operator, and prepared a report dated September 26, 2001. DX31. Dr. Renn is Board Certified in Internal Medicine and Pulmonary Medicine and a certified B-reader. Dr. Renn listed each piece of medical evidence that he reviewed and then provided a summary of the data in broad categories such as "cardiopulmonary history". At the end of his report, Dr. Renn states his impression that Mr. Burke died of lung cancer. He goes on to explain that to a reasonable degree of medical certainty, the mild form of pneumoconiosis that he had did not cause or contribute to his demise. Mr. Burke's lung cancer was not caused by his coal dust exposure or by the simple coal workers' pneumoconiosis that he had. DX31.

Deposition Testimony

Exhibit	Date	Physician
DX36-31	07/07/93	Dahhan, Dr. Abdul K.
DX36-31	07/19/93	Burke, William
DX36-33	08/27/93	Broudy, Dr. Bruce C.
EX1	08/05/02	Tuteur, Dr. Peter G.
EX2	08/07/02	Oesterling, Dr. Everett
EX3	08/08/02	Renn, Dr. Joseph J.

Dr. Dahhan was deposed on July 7, 1993. DX36-31. He is Board Certified in Internal

Medicine and Pulmonary Medicine. Dr. Dahhan explained the procedure he followed in the course of his examination including a description of each test. He then explained his opinion that Mr. Burke has chronic bronchitis and COPD due to cigarette smoking, but not enough evidence to justify the diagnosis of coal workers' pneumoconiosis. Dr. Dahhan explained how the objective test results correlated to his opinion.

Mr. Burke was deposed in his life claim on July 19, 1993. DX36-31. At that time, he was 54 years old. Mr. Burke recounted that his last day of coal mine employment was on February 22, 1992 due to an injury sustained on February 2, 1992. Mr. Burke described his jobs as "construction work". He set drill blocks, maintained the belt line, set crib blocks, and put in seals. His last coal mine employment was from February 1991 to February 22, 1992, when he worked in Wyoming. Mr. Burke testified that his job required lifting over 100 pounds, standing for eight to ten hours per day, plus stooping, bending, and climbing. Following his injury, Mr. Burke filed a workers' comp claim and filed for Social Security disability.

Mr. Burke testified regarding his smoking history that he probably started at age eighteen or twenty smoking one-half pack per day and continued to smoke at the time of his deposition (July 1993).

Dr. Broudy is Board Certified in Internal Medicine and Pulmonary Medicine, and a certified B-reader. Dr. Broudy explained what coal workers' pneumoconiosis is, how it develops, and how it manifests itself in coal miners. Dr. Broudy discussed pulmonary function tests, and their significance in the determination of the extent of pulmonary disability in a person. Dr. Broudy explained how the objective tests results supported his opinion that Mr. Burke does not have coal workers' pneumoconiosis and does not have significant pulmonary impairment. Mr. Burke has a pulmonary capacity to return to regular coal mine employment. DX 36-33.

Dr. Tuteur gave his deposition on August 5, 2002. EX1. He began by explaining his education, experience, and credentials. Dr. Tuteur is an Associate Professor of Medicine at Washington University School of Medicine in St. Louis, Missouri. He is Board Certified in Internal Medicine and Pulmonary Medicine, and the Director of the Pulmonary Function Lab at Barnes-Jewish Hospital. Dr. Tuteur explained his current duties as the medical school instructor and clinician, and the expansive array of journal articles he reviews on a regular basis.

Dr. Tuteur reviewed a set of medical data regarding Mr. Burke, and explained in detail his findings and conclusions. At the time of his death, Mr. Burke was being treated for metastatic squamous cell carcinoma for which there was no hope of cure, just some palliation. Also at the time of his death, he had a mild form of simple coal workers' pneumoconiosis. Dr. Tuteur explains how simple coal workers' pneumoconiosis can develop into a breathing problem for a person, but then explains that in Mr. Burke that never happened. Mr. Burke had a mild obstructive abnormality which did not improve after bronchodilators. At rest, his gas exchange just showed some mild impairment, but with exercise it improved "dramatically", which is typical of cigarette smoke chronic bronchitis. EX1.

Dr. Oesterling gave his deposition testimony on August 7, 2002. EX2. Dr. Oesterling began by describing his qualifications. Dr. Oesterling has earned certifications in anatomic pathology, clinical pathology, and nuclear medicine. He is Chairman of the Department of Pathology at Ohio Valley. Dr. Oesterling has an extensive history of experience studying the lungs of coal miners. Dr. Oesterling explained how the slides of Mr. Burke's lungs were prepared. They were "professionally" done giving a representative sample of his lungs. Dr. Oesterling explains that he reviewed the slides, and prepared a report and 34 photo micrographs. He examines each slide with the naked eye and then under various strengths of magnification from 60 power to 600 power. Dr. Oesterling has a special microscope which allows him to make videotape and color photographs of the images under the scope.

Dr. Oesterling explained how pathologists classified the changes that occur in a miner's lungs due to coal dust exposure. It begins with the deposition of pigment called anthracosis. If the condition becomes worse, he will observe deposits of dust around the bronchioles. Worse than that will be an irritation reaction and the body will lay down scar. If the condition continues to

advance, there will be central nodule which is the body's attempt to entrap the dust with scar tissue. Once there is a development of micronodules the condition becomes worse as the nodules grow in size and become more numerous. When nodules reach two centimeters or more, the person has progressive massive fibrosis.Dr. Oesterling stated the following with regard to his findings about Mr. Burke:

> The changes that I saw due to the mine dust, as I said, were primarily limited to the pleura. The changes in the interstitium of the lung, the parenchyma of the lung, were very, very minimal. There was not enough dust there to alter structure. And if it did not alter the functioning structure, the alveolar sacs we have illustrated, if those were not damaged by the mine dust, then indeed it did not alter function. Without alteration in function, there would have been no lifetime disability based on the mine dust exposure. Nor would it in any way have hastened, contributed or caused this gentleman's death.

Dr. Oesterling finished his deposition explaining in more detail his microscopic findings and their significance.

Dr. Renn provided deposition testimony on August 8, 2002. EX3. Dr. Renn is a pulmonologist. He is Board Certified in Internal Medicine and Pulmonary Medicine, and restricts his practice to pulmonary and occupational lung disease. Dr. Renn is also certified as a B-reader. Dr. Renn is a Clinical Associate Professor of Medicine at West Virginia University. Dr. Renn examines and treats coal miners every day in his private practice. Dr. Renn testified regarding lung disease, in general, and, more specifically regarding coal workers' pneumoconiosis. He described the medical evidence he reviewed regarding Mr. Burke, and the conclusion he reached based upon that evidence. Dr. Renn opines that Mr. Burke had a very mild degree of coal workers' pneumoconiosis that was not detectable while he was alive; only by autopsy and microscopic analysis was it detectable. Dr. Renn opines that Mr. Burke's mild simple coal workers' pneumoconiosis did not cause his death, contribute to his death, or hasten his death. EX3.

Pneumoconiosis

For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 718.201. A report of an autopsy or biopsy submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure has been performed to obtain a portion of a lung, the evidence shall include a copy of the surgical note and the pathology report of the gross and microscopic examination of the surgical specimen. If an autopsy has been performed, a complete copy of the autopsy report shall be submitted to the Office. 20 CFR 718.106 (a).

An autopsy was performed on Mr. Burke by Dr. Bathija on November 29, 1997. DX4. Dr. Bathija reports the following diagnoses for the chest:

1. Atherosclerosis, coronary arteries, moderate to severe, right and left;
2. Hypertrophy, heart, right ventricle (560 grams);
3. Enlarged lymph nodes, hilar with focal granuloma, calcification, predominately left;
4. Emphysema, congestion, edema, lungs, bilateral;
5. Coal workers' pneumoconiosis, simple with occasional nodule, bilateral;
6. Bullet, right lung, hilar, upper lobe, superficial.

With regard to the microscopic examination of the respiratory system, he reports the following:

> Respiratory system: multiple sections from the right and left lung show congestion of

lungs with emphysema, focal atelectasis, focal interstitial fibrosis with deposition of anthracotic pigment in the alveoli surrounding the blood vessels and also in subpleural area where the pleura shows focal thickening, fibrosis, deposition of anthracotic pigment and silica particles. Some of the nodules are large. One of the polyploidal nodes in the left lung upper lobe show fibrosis, hyalinization with deposition of anthracotic pigment and calcification. The lungs show simple coal workers' pneumoconiosis with focal nodular. The hilar lymph nodes are markedly enlarged, show fibrosis, calcification, marked deposition of anthracotic pigment. One of the lymph nodes in the hilar area show a metastatic poorly differentiated carcinoma which consists of a single moderately pleomorphic polyhedral two spindle shaped cells with markedly enlarged nuclei with prominent nucleoli, occasional mitosis. There is no gland formation, no keratinization. There are occasional binucleated cells. In the center focally, the metastatic tumor shows necrosis. There is no carcinoma of the lung. The autopsy was limited to chest only. There is no known primary carcinoma. The slides were reviewed by Dr. Ally who concurs with the diagnosis of metastatic poorly differentiated carcinoma.

Approximately three years after he performed the autopsy on Mr. Burke, the Department of Labor asked Dr. Bathija to provide a detailed rationale as to the cause of Mr. Burke's death. DX23. He responded with the following comments:

> With reference to your letter dated November 27, 2000, I reviewed the slides and autopsy report, A97-10 (Burke, William). The patient has coal workers' pneumoconiosis with pleural fibrosilicotic and anthracotic nodules. The autopsy did not show any primary tumor in lung, but had poorly differentiated metastatic carcinoma of lymph nodes, left hilum. The death certificate was signed by coroner, Mr. Clyde Creech, and not a physician. I am not sure how he got CA of the lung with metastasis. I have not seen the patient and not much clinical information was available, hence, it is difficult for me to give a definite opinion. All I can say is coal workers' pneumoconiosis may have contributed to Mr. William Burke's death. Clinical correlation is suggested.

The death certificate was signed by the county coroner, a non-physician, who indicates that Mr. Burke died of lung cancer. DX3.

A review of the autopsy shows that it meets the quality standards set forth above.[9] The tissue slides of the lungs prepared by Dr. Bathija at the time of the autopsy were evaluated by Dr. Perper for the Department of Labor (DX24), Dr. Naeye (DX25), Dr. Caffrey (DX30), and Dr. Oesterling (DX32), all for the Operator. All of these pathologists found evidence of very mild, simple coal workers' pneumoconiosis. The autopsy clearly determined that anthracosis or anthracofibrosis were present in Mr. Burke's lungs, and Dr. Perper must be credited as he noted that they are reliable indicators of occupational exposure to mixed coal mine dust containing silica. I note that only four of the twenty x-ray readings in the life claim were positive for pneumoconiosis, but I accept that the pathological studies from an autopsy are more accurate than x-rays.[10] I may accept the evidence of coal workers' pneumoconiosis which is based on autopsy slides. ***Turlip v. Director***, O.W.C.P., 8 BLR 1-363 (1985). And there is no reason to discount the pathologists' opinions on this issue. Therefore, after a review of all of the evidence of

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[9] An autopsy report should be found in compliance with the quality standards unless there is good cause to believe that the autopsy report is not accurate or that the condition of the miner is being fraudulently represented. ***McLaughlin v. Jones & Laughlin Steel Corp***., 2 B.L.R. 1-103, 1-108 (1979). See 20 C.F.R. § 718.106 (2000).

[10] The Board has held that an administrative law judge is not required to defer to the numerical superiority of x-ray evidence, ***Wilt v. Wolverine Mining Co.***, 14 B.L.R. 1-70 (1990),); for example in ***Tokaricik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1984) (the judge properly assigned greater weight to the positive x-ray evidence of record, notwithstanding the fact that the majority of x-ray interpretations in the record, including all of the B-reader reports, were negative for existence of the disease).

record, I accept that the evidence supports a finding of a very mild form of simple coal workers' pneumoconiosis.

If a miner who is suffering from pneumoconiosis was employed for ten or more years in one or more coal mines, there is a rebuttable presumption that his pneumoconiosis arose out of such employment under 20 CFR §718.203(b). In Mr. Burke's case, the Employer has stipulated to twenty one (21) years of coal mine employment and therefore this rebuttable presumption applies.

Although I accept that the record shows that Mr. Burke has pneumoconiosis, I also must find that condition did not cause or hasten his death. The record shows that during his lifetime, although treating physicians had determined the presence of pneumoconiosis on the basis of x-ray and examination, the record does not establish that he was totally disabled as a result of pneumoconiosis during his lifetime (See DX 36). The Claimant has a duty to provide probative evidence. And the Claimant stipulates that Mr. Burke was not disabled during his lifetime (Tr 7-8).

Evaluation of the Evidence

The Regulations at Part 718 apply to survivor's claims which are filed on or after April 1, 1980. Mrs. Burke filed her claim in July of 2000. DX 1. By the date of the filing of the claim, review of the evidence under the issue of death due to pneumoconiosis is governed by the Regulations at §718.205(c).

As discussed above in part, under 20 CFR §718.205(c), a claimant may establish that death is due to pneumoconiosis in any of the following circumstances:

1. Where competent medical evidence establishes that the miner's death was due pneumoconiosis; or
2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where death was caused by complications of pneumoconiosis; or
3. Where the presumptions set forth at §718.304 apply (this presumption of complicated pneumoconiosis is not available here).

Survivors are not eligible for benefits where the miner's death was caused by traumatic injury or where the principle cause of death was a medical condition unrelated to pneumoconiosis as in §718.205(c)(4). In a survivor's claim filed after January 1, 1982, the evidence must establish that the decedent miner's death was due to pneumoconiosis, and not due to a medical condition unrelated to pneumoconiosis. ***Neeley v. Director, OWCP***, 11 BLR 1-85(1988).

This claim arises within the jurisdiction of the United States. Court of Appeals for the Tenth Circuit since the last year of coal mine employment took place in Wyoming. DX36-60 at 9.

Survivors are not eligible for benefits when the miner's principal cause of death was a medical condition not related to pneumoconiosis, unless the pneumoconiosis was a substantially contributing cause of his death. 20 C.F.R. §718.205(c)(4); ***Neeley v. Director, O.W.C.P.***, 11 BLR 1-85 (1988). Employer asserts that pneumoconiosis never interfered with the functioning of Mr. Burke's lungs, and therefore never was a contributing cause of his death..

Mrs. Burke asserts that in 1975 Mr. Burke was examined by a physician, x-rays were taken and she was sent a letter advising him not to work in coal mine employment, but the letter has been lost or misplaced. First, the allegation is not substantiated in the remainder of the record. Second, Mr. Burke returned to work and remained employed in coal mine employment until 1992. And more importantly, even if the Miner had been so advised, an opinion of the inadvisability of returning to coal mine employment because of pneumoconiosis is not the equivalent of a finding of total disability. ***Zimmerman v. Director, OWCP***, 871 F.2d 564, 567 (6th Cir. 1989); ***Taylor v. Evans & Gambrel Co.***, 12 B.L.R. 1-83 (1988); ***Justice v. Island Creek Coal Co.***, 11 B.L.R. 1-91 (1988); ***Bentley v. Director, OWCP***, 7 B.L.R. 1-612 (1984); ***Brusetto v. Kaiser Steel Corp***., 7 B.L.R. 1-422 (1984).

I accept that Mrs. Burke is credible, but I do not accept that she is competent to determine causation and I do not accept that just because Mr. Burke has pneumoconiosis with severe bouts of cough and exuded sputum, that I can extend her allegations to a render a determination that she

meets the criteria established by the law and regulations.

Mrs. Burke did not produce reports or opinions from any physician or any treating source that clearly shows that pneumoconiosis caused or hastened her husband's death in any manner. The following reports are crucial as to causation:

1. Death certificate from Mr. Clyde Creech, Bell County Coroner (DX3);
2. Autopsy report and opinion letter from pathologist prosector, Dr. Bathija (DX4; DX23);
3. Pathology report by Dr. Perper (DX24);
4. Pathology report by Dr. Naeye (DX25);
5. Pathology report by Dr. Caffrey (DX30);
6. Pathology report and deposition by Dr. Oesterling (DX30; EX2);
7. IMR report and deposition by Dr. Tuteur (DX28; EX1);
8. IMR report by Dr. Dahhan (DX29);
9. IMR report and deposition by Dr. Renn (DX31; EX3);
10. Medical treatment records from Dr. George Day (DX 36-56), Fort Sanders Medical Center (DX22), Dr. Richard Grapski (DX 9), Dr. Vincent Kaw (DX 7), Dr. Jerry Limler (DX 8), and Dr. McCrachren (DX 6).

Dr. Bathija's report indicates the presence of simple coal workers' pneumoconiosis, and he states that it is difficult for him to give an opinion, but pneumoconiosis *may* have contributed to Mr. Burke's death. (Emphasis added). Employer argues that Dr. Bathija has no special interest or expertise in the area of black lung disease. Beyond being a licensed physician, he has no special qualifications. Dr. Bathija is so uncertain about pneumoconiosis causing Mr. Burke's death that he admits that he cannot make that determination and then suggests clinical correlation. DX23. Employer submits that Dr. Perper, Dr. Naeye, Dr. Caffrey, and Dr. Oesterling provided clinical correlation that pneumoconiosis did not cause or hasten death.

An opinion may be given little weight if it is equivocal or vague. ***Island Creek Coal Co. v. Holdman***, 202 F.3d 873 (6th Cir. 2000) (a physician, who concluded that simple pneumoconiosis "probably" would not disrupt a miner's pulmonary function, was equivocal and insufficient to "rule out" causal nexus as required by 20 C.F.R. § 727.203(b)(3)); ***Griffith v. Director***, OWCP, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably had black lung disease); ***Justice v. Island Creek Coal Co.***, 11 B.L.R. 1-91 (1988) (an equivocal opinion regarding etiology may be given less weight); ***Parsons v. Black Diamond Coal Co.***, 7 B.L.R. 1-236 (1984) (equivocal regarding disability). I attribute some weight to the Bathija opinion, but as it is unexplained, I must attribute greater credit to the opinions Dr. Perper, the Department of Labor expert and those of the other pathologists.[11]

A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. ***Hoffman v. B&G Construction*** Co., 8 B.L.R. 1-65 (1985); ***Hess v. Clinchfield Coal Co.***, 7 B.L.R. 1-295 (1984); ***Justus v. Director, OWCP***, 6 B.L.R. 1-1127 (1984). Indeed, a treating physician's opinion based only upon a positive x-ray interpretation and claimant's symptomatology was deemed sufficiently documented. ***Adamson v. Director, OWCP***, 7 B.L.R. 1-229 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions. ***Fields***, *supra.* Indeed, whether a medical report is sufficiently

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[11] I accept his findings, and his opinions as to other causes of death, but not as to pneumoconiosis When asked a direct question as to whether pneumoconiosis was a cause, he gave an equivocal answer. In ***Drummond Coal Co. v. Freeman***, 17 F.3d 361 (11th Cir. 1994), the Eleventh Circuit held that an administrative law judge "need not . . . find that a medical opinion is either wholly reliable or wholly unreliable"; rather, the opinion may be divided into the relevant issues of entitlement to determine whether it is reasoned and documented with regard to any particular issue.

documented and reasoned is for the judge as the finder-of-fact to decide. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149 (1989)(en banc).

The autopsy slides prepared by Dr. Bathija were sent to Dr. Perper and he reviewed the slides and the available medical records on Mr. Burke. DX24. Dr. Perper is Professor of Pathology and Epidemiology at the University of Miami School of Medicine. DX24A. Dr. Perper reviewed the twenty autopsy slides and a long list of documentary evidence. After considering all of the Miner's treatment records, Dr. Perper rendered an opinion that within a reasonable degree of medical certainty that: the clinical, radiological and pathological findings do not support the assumption that coal workers pneumoconiosis was a substantial contributory cause or a hastening factor in Mr. Burke s death. To the contrary, the most likely cause of Mr. Burke s demise was a fatal arrhythmia on the background of his severe arteriosclerotic heart disease and old myocardial infarction. Dr. Perper explains that Mr. Burke's form of mild, simple coal workers' pneumoconiosis was limited primarily to the pleural and immediate subpleural area. DX24.

Dr. Naeye is Professor of Pathology at Pennsylvania State University College of Medicine. DX25. Dr. Naeye provides a well written report explaining how the objective test results prove that in September 1996, just fourteen months prior to Mr. Burke's death, Mr. Burke had such a mild pulmonary impairment that he retained the lung function to perform his last job. As did Dr. Perper before him, Dr. Naeye observed in tissue slides micronodules of simple CWP in the subpleural sites. He was the only observer to quantify the amount of lung tissue affected by the macules and micronodules. He observed that they occupy less than 2% of the lung tissue.

Dr. Caffrey is Board Certified in Anatomical and Clinical Pathology. DX30. He reviewed the twenty autopsy slides as well as all the documentary medical evidence. Dr. Caffrey discusses at length the objective test data and how it demonstrates that Mr. Burke had good lung function, which means that his simple coal workers' pneumoconiosis was so mild that it did not cause him any pulmonary disability or hasten his death. DX30.

Dr. Oesterling was the final pathologist to review the slides. DX32. Dr. Oesterling is the Chairman of the Department of Pathology at Ohio Valley General Hospital in Pittsburgh, Pennsylvania. Dr. Oesterling explains that Mr. Burke's micronodular CWP was limited to his pleura and immediate subpleural tissues and it did not effect the parenchyma of the lungs. Dr. Oesterling opines that Mr. Burke's pneumoconiosis was too mild to cause him any pulmonary disability or be a contributing factor to his death.

The evidentiary record contains medical treatment records from multiple sources. DX36-56; DX22; DX9; DX7; DX8; and DX6. These medical records support the opinions of Drs. Perper, Naeye, Caffrey, and Oesterling. Mr. Burke suffered from back pain and epigastric pain and then in April 1997 was found to have a large right, upper lung malignant tumor.

Drs. Tuteur, Dahhan, and Renn provided reports for the Operator after reviewing all of the evidence in the records. DX28; DX29; DX31. They are all Board Certified in Internal Medicine and Pulmonary Medicine. Dr. Dahhan was unique in that he also personally examined Mr. Burke on October 22, 1992. DX36-10. Dr. Dahhan explained that Mr. Burke's exposure to coal dust caused him no pulmonary impairment and he would have died at the same time in the same if he had never worked in the coal mines. DX29. Dr. Tuteur explained that while Mr. Burke was alive his coal workers' pneumoconiosis was so mild it was undetectable, and therefore could not have caused him any pulmonary disability. DX28. Dr. Renn opined that Mr. Burke died because he had developed lung cancer and his coal workers' pneumoconiosis was too mild to have any detrimental affect. All of these opinions substantiate and the views expressed are accommodated in the rationale of Dr. Perper.

Each of the Operator's experts, pathologists, internists and pulmonologists, fully substantiate Dr. Perper's opinion and logic. The lone contrary opinion is expressed by the Death Certificate. No contrary physician opinions have been produced. Based on a review of all of the evidence, I find that Dr. Perper's report is the most thorough, most rational and most convincing of record and his opinion is entitled to significant weight. ***Fields****, supra and* ***Clark*** *supra*.

I attribute no weight to the cause of death listed by the Death Certificate (DX 3) as the opinion is not based on medical science and is contrary to the full weight of the evidence. It is clear that the Miner did not have cancer at time of death. A death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for an administrative law judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. ***Smith v. Camco Mining,*** Inc., 13 B.L.R. 1-17 (1989); ***Addison v. Director***, OWCP, 11 B.L.R. 1-68 (1988).[12] The Coroner was not a physician and all of the pathologists in this case are better qualified that he to render an opinion as to cause of death.

I give limited weight to the opinions expressed by physicians in the Miner's life claims as the issue is cause of death and the record is only tangentially relevant to that issue. In essence, the pathology in this case trumps the life claim evidence.

Therefore, after a review of the entire record, the Claimant has failed to carry her burden of proof in this matter. I accept Dr. Bathija's diagnosis of pneumoconiosis, but his reports are not helpful as to causation, because they are equivocal. ***Island Creek Coal Co. v. Holdman***, ***Griffith v. Director***, ***Justice v. Island Creek Coal Co.***, ***Parsons v. Black Diamond Coal Co.***, all *supra*. Dr. Perper's opinion went directly to the issue of causation, and using Dr. Bathija's results and findings, on a line by line, item by item basis, he unequivocally determined that pneumoconiosis does not play any part in hastening death in any way in this record (DX 24). In addition, all of the Operator's witnesses agree with Dr. Perper's diagnosis and his logic. I find that this is most persuasive, especially considering that there is no contrary opinion that pneumoconiosis played any role in Mr. Burke's demise.

Conclusion

The Claimant has failed to establish that her late spouse's demise was caused by or hastened by pneumoconiosis. The Claimant had a duty to provide persuasive evidence of entitlement and has failed to do so. ***Oggero v. Director, OWCP***, *supra*.

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Daniel F. Solomon
Administrative Law Judge

Notice of Appeal Rights. Pursuant to 20 C.F.R. §§ 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Workers' Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601. See 20 C.F.R. §§§§ 725.478 and 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, D.C. 20210.

[12] Similarly, in ***Lango v. Director, OWCP***, 104 F.3d 573 (3d Cir. 1997), the court adopted the Eighth Circuit's holding in ***Risher v. Office of Workers' Compensation Programs***, 940 F.2d 327, 331 (8th Cir. 1991), to state that "the mere fact that a death certificate refers to pneumoconiosis cannot be viewed as a reasoned medical finding, particularly if no autopsy has been performed." See also ***Bill Branch Coal Co. v. Sparks***, 213 F.3d 186 (4th Cir. 2000) (a death certificate stating that pneumoconiosis contributed to the miner's death, without some further explanation, is insufficient).